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December 5, 2016

Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

RE: Proposed Comments Request for the Annual Return Report of Employee Benefit Plans
Regulatory Identifier Number (RIN 1210-AB63)

Dear Sir or Madam,

In response to your request for comments on the proposed changes to the Form 5500 annual report for employee benefit plans, Gilsbar, L.L.C. (Gilsbar) provides the below response. Gilsbar is a Third Party Administrator (TPA) for large and small employer benefit plans, including a few governmental, religious, and tribal plans.

The proposed changes to Form 5500 create a considerable administrative and financial burden on all employers, and this universal burden will far outweigh any benefit the Department of Labor (DOL) would gain from receiving this information. For instance, the majority of information requested in the proposed regulation, specifically Schedule J to the Form 5500, entails complex reporting and in many instances, building processes and systems to collect the requested data, in order to submit the information to the DOL. In specific cases, if this invasive information is needed, the DOL can individually request it. Because the scope of the request is so large and burdensome, it greatly increases the risk that employers will inadvertently be non-compliant because they cannot provide complete information. This extensive information request will take an enormous amount of time and resources for employers to fulfill. Researching and compiling the information will force employers to reallocate personnel resources to accommodate dedicating an employee, or in some cases multiple employees, solely to completing and filing the Form 5500. For nearly all of our clients, this complex reporting is not something that they have the means or feasibility to accomplish completely on their own. As such, the reporting requirements will force these employers to incur costs by outsourcing the reporting obligation to a current service provider or a new third party vendor. Regardless of whether the reporting is handled in-house or outsourced, all clients will incur a significant financial burden if this proposed regulation is enacted.

Additionally, for the small, fully insured group health plans with fewer than 100 participants, eliminating the reporting exemption will require a large number of groups that did not provide reporting in the past to spend a vast amount of time becoming familiar and complying with the reporting requirements. Consequently, these groups would be at risk for non-compliance by providing incorrect or incomplete information.

As a TPA, we play an integral role in assisting our clients by providing the required information for them to correctly and completely file the Form 5500. With the new requirements on the Schedule J to

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the Form 5500, we will be required to charge to provide broad reports to our employer clients, especially with the proposed elimination of the small, fully insured group health plan exemption. This will substantially increase the number of reports that we need to produce, review, and distribute, thus creating the need to hire additional employees. Much of the information requires gathering specific names, not just statistical information. Due to the extensive information required by the Schedule J, systems will need to be programmed and updated so we can accurately and timely provide the requested information. Due to the factors listed above, the cost to provide these reports will increase significantly, which requires us to pass down the cost to our clients. No justification has been offered to rationalize this burdensome obligation.

A few examples of how the proposed Schedule J would affect our TPA business are listed below:

1. Reporting on detailed claims payment data would be problematic to track and provide due to the sheer volume of claims that plans incur throughout the plan year and the timing for which claims for same dates of service are received. Also, the reporting requested would not give an accurate depiction of the plan's operations as various factors and supporting documentation determine whether claims are approved, denied, or appealed.

2. Reporting on the plan's inability to pay claims during the plan year is complex as there could be a different interpretation on the inability to pay claims. Would this require reporting on plans that are late on funding their claims account or would this only consist of reporting when the group completely fails to fund their claims account? Clarification would be required in order for plans to properly and accurately report on this item.

3. Reporting on approved and denied claims as well as the total dollar amount of claims paid is vague, over-simplified and disconnected from reality. When reporting on "approved" or "denied" claims, to what degree of specificity will the plan be required to provide the information? Will the plan need to drill down to a line item level? What if only a portion of a claim is covered – does that count as an "approved" claim or a "denied" claim or both? Does the total dollar amount of claims paid require documentation regarding the original charges versus the negotiated charges? This granular reporting will be quite difficult if specific details are required. If plans are required to report on the specifics of approved versus denied claims and the dollar amount of denied claims and claims paid, this reporting would require additional programming to our claims and reporting systems, which is time consuming and expensive to develop and would put a significant financial strain on our business as we would be required to hire staff and allocate additional resources to assist our employer clients with obtaining this information. Additionally, reporting on the dollar amount of denied claims does not accurately depict whether or not the claim was eventually approved and paid. A claim could initially be denied due to insufficient information and later perfected and resubmitted by the provider under a different claim number. Because the two claim numbers are not linked, the raw data reported would not accurately reflect whether or not the claim was eventually approved. Instead, it might inaccurately show that a plan tends to deny claims rather than approve them.

4. Reporting on the approximate number of participants and beneficiaries covered under the plan at the end of the plan year is also burdensome to track and report as our employer clients have complex plan designs with many possible ways they could identify participants and beneficiaries

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for each subset of their total population. For example, would plans be required to report on a plan's retiree and active populations? What if a plan has a large population of Medicare primary participants or tribal members? This type of breakdown requires a manual process that involves multiple layers of quality assurance to confirm the accuracy of the information. As such, this manual process would also be laborious and would put a financial strain on our business, as we would be required to hire additional staff to complete this reporting requirement.

5. Reporting on group health benefits offered under the plan and whether the plan complies with applicable laws such as HIPAA, GINA, mental health parity, and other mandates is difficult to track as this information would need to be manually pulled from multiple sources. While surgical, prescription, mental health, substance abuse, and preventive care would all typically be covered, a review of the plan documents is necessary to confirm the plan is reporting accurate information and in compliance with applicable laws. This would require a dedicated staff member to research and collect the information manually from our many clients' plans. Electronic tracking of the information would require additional time and significant financial resources to build.

6. Reporting on participant or employer contributions is not currently documented for each employer client, nor is it often disclosed to us. For us to provide this information for our client, we would need to require the plan to provide this information and we would need to utilize additional technological resources to create a program for electronically tracking contributions.

7. Reporting on whether a plan is a high deductible health plan, an FSA, or an HRA is another reporting requirement that involves a manual review of each plan document to determine whether these items are included. Again, this requirement would require manual review of the plan document as well as additional resources to create a program for electronic tracking of this information.

While the information requested with the additional reporting requirements seems straight-forward and easily obtainable on its face, the proposed additional reporting cannot be fulfilled by simply creating a formula to run a report and having the information easily at your fingertips. Upon further careful examination of the request, we have determined these additional requirements to be laborious and financially prohibitive for employers.

In closing, we ask that you take into consideration the inability of these employers and TPAs to easily comply with your request and balance that inability against the reasonableness and feasibility of the request before enacting the proposed legislation. Alternatively, if you decide to enact the proposed regulation, we strongly urge you to consider postponing the implementation of this regulation for a minimum of three years to allow TPAs and employers the ability to create the systems necessary to provide the requested information.

Sincerely,

Ashley M. Flick

Ashley M. Flick
Loss Prevention Counsel